		FOR OHF USE					

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045245

Facility Name: Prairie Rose Health Care Center

Address: 900 S. Chestnut Street (Number) Pana (City) 62557 (Zip Code)

County: Christian

Telephone Number: (217) 562-3996 **Fax #** (217) 562-4005

IDPA ID Number: 431710785001

Date of Initial License for Current Owners: 01/01/00

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	x	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code				Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Christine A. Hanover **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/03 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANTS' COMPILATION REPORT (Date)
	(Print Name and Title)	
	(Firm Name & Address)	Altschuler, Melvoin and Glasser LLP One South Wacker Drive, Suite 800, Chicago, IL 60606
	(Telephone)	(312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	121	Skilled (SNF)	121	44,165	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	121	TOTALS	121	44,165	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,956		2,381	5,337	8
9	SNF/PED					9
10	ICF	23,487	2,625		26,112	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,443	2,625	2,381	31,449	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.21%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 3/1/1995

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 3/1/1995 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 25 and days of care provided 2,381

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	154,588	10,738	4,206	169,532		169,532	220	169,752			1
2	Food Purchase		119,602		119,602		119,602	(747)	118,855			2
3	Housekeeping	35,855	9,882	51,081	96,818		96,818		96,818			3
4	Laundry	4,082	11,925	32,534	48,541		48,541		48,541			4
5	Heat and Other Utilities			84,998	84,998		84,998	595	85,593			5
6	Maintenance	31,560	2,672	47,058	81,290		81,290	2,532	83,822			6
7	Other (specify):*											7
8	**TOTAL General Services**	226,085	154,819	219,877	600,781		600,781	2,600	603,381			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,137,661	132,619	35,243	1,305,523		1,305,523		1,305,523			10
10a	Therapy		29,634	124,927	154,561		154,561		154,561			10a
11	Activities	42,937	505	1,934	45,376		45,376		45,376			11
12	Social Services	92,061	113	2,008	94,182		94,182		94,182			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,272,659	162,871	164,112	1,599,642		1,599,642		1,599,642			16
	C. General Administration											
17	Administrative	94,108		96,841	190,949		190,949	(96,841)	94,108			17
18	Directors Fees											18
19	Professional Services			50,622	50,622		50,622	13,964	64,586			19
20	Dues, Fees, Subscriptions & Promotions			5,415	5,415		5,415	304	5,719			20
21	Clerical & General Office Expenses	96,743	11,474	48,795	157,012		157,012	15,309	172,321			21
22	Employee Benefits & Payroll Taxes			220,358	220,358		220,358	17,299	237,657			22
23	Inservice Training & Education							432	432			23
24	Travel and Seminar			3,779	3,779		3,779	1,471	5,250			24
25	Other Admin. Staff Transportation			4,585	4,585		4,585	1,565	6,150			25
26	Insurance-Prop.Liab.Malpractice			160,913	160,913		160,913	762	161,675			26
27	Other (specify):*											27
28	**TOTAL General Administration**	190,851	11,474	591,308	793,633		793,633	(45,735)	747,898			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,689,595	329,164	975,297	2,994,056		2,994,056	(43,135)	2,950,921			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

** See schedule of adjustment attached at end of cost report.

Facility Name & ID Number Prairie Rose Health Care Center #0045245 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			147,263	147,263		147,263	5,661	152,924			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			233,822	233,822		233,822	(410)	233,412			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							2,836	2,836			34
35	Rent-Equipment & Vehicles			36,385	36,385		36,385	556	36,941			35
36	Other (specify):* MIP Insurance			18,155	18,155		18,155		18,155			36
37	TOTAL Ownership			435,625	435,625		435,625	8,643	444,268			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		94,634	455	95,089		95,089		95,089			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			60,801	60,801		60,801		60,801			42
43	Other (specify):* Nonallowable Costs			215,986	215,986		215,986	(215,986)				43
44	TOTAL Special Cost Centers		94,634	277,242	371,876		371,876	(215,986)	155,890			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,689,595	423,798	1,688,164	3,801,557		3,801,557	(250,478)	3,551,079			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/03 Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(747)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	761	30		9
10	Interest and Other Investment Income	(10,531)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(18,655)	43		18
19	Entertainment	(2,250)	43		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(148,070)	43		24
25	Fund Raising, Advertising and Promotional	(10,965)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached Schedule 5A	(37,208)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (227,665)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(22,813)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (22,813)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (250,478)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Prairie Rose Health Care Center

ID# 0045245

Report Period Beginning: 01/01/03

Ending: 12/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

Prairie Rose Health Care Center
Provider #0045245
12/31/2003

Schedule 5A

VI. ADJUSTMENT DETAIL
NON-ALLOWABLE EXPENSES
LINE 29 - Other

Description	Amount	Schedule V Reference
Offset miscellaneous income	(1,162)	21
Laboratory	(35,645)	43
X - ray	(401)	43
	(37,208)	

See Accountants' Compilation Report

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	220	0	0	0	0	0	0	0	0	0	220	1
2	Food Purchase	(747)	0	0	0	0	0	0	0	0	0	0	(747)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	595	0	0	0	0	0	0	0	0	0	595	5
6	Maintenance	0	2,532	0	0	0	0	0	0	0	0	0	2,532	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(747)	3,347	0	0	0	0	0	0	0	0	0	2,600	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(96,841)	0	0	0	0	0	0	0	0	0	(96,841)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	13,964	0	0	0	0	0	0	0	0	0	13,964	19
20	Fees, Subscriptions & Promotions	0	304	0	0	0	0	0	0	0	0	0	304	20
21	Clerical & General Office Expenses	0	16,471	0	0	0	0	0	0	0	0	0	16,471	21
22	Employee Benefits & Payroll Taxes	0	17,299	0	0	0	0	0	0	0	0	0	17,299	22
23	Inservice Training & Education	0	432	0	0	0	0	0	0	0	0	0	432	23
24	Travel and Seminar	0	1,471	0	0	0	0	0	0	0	0	0	1,471	24
25	Other Admin. Staff Transportation	0	1,565	0	0	0	0	0	0	0	0	0	1,565	25
26	Insurance-Prop.Liab.Malpractice	0	762	0	0	0	0	0	0	0	0	0	762	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	(44,573)	0	0	0	0	0	0	0	0	0	(44,573)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(747)	(41,226)	0	0	0	0	0	0	0	0	0	(41,973)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	761	4,900	0	0	0	0	0	0	0	0	0	5,661	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(10,531)	0	10,121	0	0	0	0	0	0	0	0	(410)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	2,836	0	0	0	0	0	0	0	0	2,836	34
35	Rent-Equipment & Vehicles	0	0	556	0	0	0	0	0	0	0	0	556	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(9,770)	4,900	13,513	0	0	0	0	0	0	0	0	8,643	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(179,940)	0	0	0	0	0	0	0	0	0	0	(179,940)	43
44	**TOTAL Special Cost Centers**	(179,940)	0	0	0	0	0	0	0	0	0	0	(179,940)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(190,457)	(36,326)	13,513	0	0	0	0	0	0	0	0	(213,270)	45

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		See attached Schedule 6A		See attached Schedule 6A		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$	Petersen Health Care Companies	0.00%	$ 220	$ 220	1
2	V	5	Utilities		Petersen Health Care Companies	0.00%	595	595	2
3	V	6	Maintenance supplies		Petersen Health Care Companies	0.00%	2,532	2,532	3
4	V	17	Administrative	96,841	Petersen Health Care Companies	0.00%		(96,841)	4
5	V	19	Professional services		Petersen Health Care Companies	0.00%	13,964	13,964	5
6	V	20	Dues, fees & subscriptions		Petersen Health Care Companies	0.00%	304	304	6
7	V	21	Clerical & general office		Petersen Health Care Companies	0.00%	16,471	16,471	7
8	V	22	Employee benefits		Petersen Health Care Companies	0.00%	17,299	17,299	8
9	V	23	Inservice training & education		Petersen Health Care Companies	0.00%	432	432	9
10	V	24	Travel & seminar		Petersen Health Care Companies	0.00%	1,471	1,471	10
11	V	25	Other admin. staff transport		Petersen Health Care Companies	0.00%	1,565	1,565	11
12	V	26	Insurance-property & liab.		Petersen Health Care Companies	0.00%	762	762	12
13	V	30	Depreciation		Petersen Health Care Companies	0.00%	4,900	4,900	13
14	Total			$ 96,841			$ 60,515	$ * (36,326)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	32	Interest	$	Petersen Health Care, Inc.	0.00%	$ 10,121	$ 10,121	15
16	V	34	Rent-facility & grounds		Petersen Health Care, Inc.	0.00%	2,836	2,836	16
17	V	35	Rent-equipment & vehicles		Petersen Health Care, Inc.	0.00%	556	556	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 13,513	$ * 13,513	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Prairie Rose Health Care Center
Provider #0045245
12/31/2003

Schedule 6A

VII Related Parties - Page 6 - owned 100 % by Mark Petersen

Related Nursing Homes	City	
In-State:		
Arcola Health Care Center	Arcola, IL	
Bement Health Care Center	Bement, IL	
Countryview Terrace	Louisville, IL	
Eastview Terrace	Sullivan, IL	
Havana Health Care Center	Havana, IL	
Kewanee Care Home	Kewanee, IL	
Palm Terrace of Mattoon	Mattoon, IL	
Prairie Rose Health Care Center	Pana, IL	
Robings Manor Nursing Home	Brighton, IL	
Royal Oaks Care Center	Kewanee, IL	
Sullivan Health Care Center	Sullivan, IL	
Sunset Manor Nursing Home	Canton, IL	
Out-of-State:		
Meadow Lawn Nursing Center	Davenport, IA	
Related Assisted Living		
Courtyard Estates	Kewanee, IL	
Other Related Business Entities		
Petersen Health Care Companies	Peoria, IL	Management/Bookkeeping
RLP Senior Villages, Inc.	Peoria, IL	Management/Bookkeeping

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Mark Petersen	President	Administrative	0 *	317,319	7.5	15.00	Salary	$ 35,181	L17,C1	1
2											2
3											3
4											4
5											5
6											6
7		* Manager									7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 35,181		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Prairie Rose Health Care Center
Provider #0045245
12/31/2003

Schedule 7A

VII Related Parties
C Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors

Name	Arcola Health Care Center	Bement Health Care Center	Countryview Terrace	Eastview Terrace	Havana Health Care Center	Kewanee Care Center	Meadow Lawn Nursing Center	Palm Terrace of Mattoon	Prairie Rose Health Care Center	Robings Manor Nursing Home	Royal Oaks Care Center	Sullivan Health Care Center	Sunset Manor Nursing Home	TOTAL
Mark Petersen	37,699	23,276	6,197	22,462	32,710	28,962	25,443	34,589	35,181	26,725	28,388	9,151	41,717	352,500

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Petersen Health Care Companies
Street Address: 7218 North Villa Lake
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 691-8113
Fax Number: (309) 691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Patient days	315,110	13	$ 2,200	$	31,449	$ 220	1
2	5	Utilities	Patient days	315,110	13	5,963		31,449	595	2
3	6	Maintenance supplies	Patient days	315,110	13	25,373		31,449	2,532	3
4	19	Professional services	Patient days	315,110	13	139,914		31,449	13,964	4
5	20	Dues, fees & subscriptions	Patient days	315,110	13	3,044		31,449	304	5
6	21	Clerical & general office	Patient days	315,110	13	165,031		31,449	16,471	6
7	22	Employee benefits	Patient days	315,110	13	173,328		31,449	17,299	7
8	23	Inservice training & education	Patient days	315,110	13	4,328		31,449	432	8
9	24	Travel & seminar	Patient days	315,110	13	14,743		31,449	1,471	9
10	25	Other admin. staff transport	Patient days	315,110	13	15,681		31,449	1,565	10
11	26	Insurance-property & liab.	Patient days	315,110	13	7,635		31,449	762	11
12	30	Depreciation	Patient days	315,110	13	49,093		31,449	4,900	12
13	32	Interest	Patient days	315,110	13	101,410		31,449	10,121	13
14	34	Rent-facility & grounds	Patient days	315,110	13	28,419		31,449	2,836	14
15	35	Rent-equipment & vehicles	Patient days	315,110	13	5,568		31,449	556	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 741,730	$		$ 74,028	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	AMI Capital, Inc.		x	Mortgage	$21,167.65	12/1/02	$ 3,580,869	$ 3,544,313	11/2035	0.0618	$ 221,036	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$21,167.65		$ 3,580,869	$ 3,544,313			$ 221,036	9
	B. Non-Facility Related*											
10								Amortization expense			12,786	10
11								Offset interest income			(10,531)	11
12												12
13								Allocated from Home Office			10,121	13
14	TOTAL Non-Facility Related						$	$			$ 12,376	14
15	TOTALS (line 9+line14)						$ 3,580,869	$ 3,544,313			$ 233,412	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 18,155 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$ N/A	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998		8
1999		9
2000		10
2001		11
2002		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Prairie Rose Health Care Center COUNTY Christian

FACILITY IDPH LICENSE NUMBER 0045245

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (309) 691-8113 FAX #: (309) 691-8622

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill whic is normally paid during 2003.

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/03 Ending: 12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,000 B. General Construction Type: Exterior Brick and Block Frame Wood Number of Stories One

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	28,000	1995	$ 13,500	1
2					2
3	TOTALS	28,000		$ 13,500	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	121		1995	1976	$ 1,068,665	$ 35,622	30	$ 35,622	$	$ 314,662	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1986 Additions			1986	970,363	32,345	30	32,345		552,567	9
10	1987 Additions			1987	110,922	3,825	29	3,825		63,672	10
11	1989 Additions			1989	2,219		10			2,219	11
12	1990 Additions			1990	4,295	143	30	143		3,815	12
13	1991 Additions			1991	134,283		7			134,283	13
14	1992 Additions			1992	17,130		7			17,130	14
15	1993 Additions			1993	24,239		7			24,239	15
16	1994 Additions			1994	10,559		7			10,559	16
17	1995 Additions			1995	14,617	974	15	974		8,676	17
18	1996 Additions			1996	305,057	25,421	12	25,421		(159,816)	18
19	1997 Additions			1997	23,542	2,354	10	2,354		14,410	19
20	Whirlpool bath			1998	9,120	912	10	912		5,472	20
21	Lift, bath trolley			1998	3,850	385	10	385		2,310	21
22	Shower room			1998	4,884	489	10	489		2,890	22
23	Entrance doors			1998	2,358	118	20	118		619	23
24	Curtains			1998	6,102	1,017	5	1,017		6,102	24
25	Sidewalk & pad			1999	1,484	99	15	99		454	25
26	Divide receipts on emergency generator			1999	2,397	120	20	120		540	26
27	Med room cabinets, counter top			1999	2,008	100	20	100		401	27
28	Heat/Cool			2000	1,876	268	7	268		893	28
29	Door alarms			2001	1,215	81	15	81		216	29
30	Dining room, living room, shower remode			2001	94,315	3,144	30	3,144		8,098	30
31	Wooded doors			2001	1,900	127	15	127		265	31
32	Landscaping - renovation project			2001	1,174	117	10	117		302	32
33	Bituminous parking lot			2001	22,030	2,754	8	2,754		5,737	33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Replace plumbing fixtures	2002	$ 2,490	$ 125	20	$ 125	$	$ 250	37
38	Therapy room remodel	2002	5,617	281	20	281		562	38
39	Remodel medication/utility rooms	2002	7,909	395	20	395		790	39
40	2 heating/cooling rooftop units	2002	11,300	1,130	10	1,130		2,260	40
41	Breakroom remodel	2002	3,106	311	10	311		622	41
42	Exterior window covering	2002	7,650	1,093	7	1,093		2,186	42
43	Lights for therapy room	2002	805	81	10	81		162	43
44	Renovation on facility floors and walls	2002	36,842	1,842	20	1,842		3,684	44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,916,323	$ 115,673		$ 115,673	$	$ 1,031,231	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 646,553	$ 30,502	$ 30,502	$	5-15 years	$ 588,257	71
72	Current Year Purchases	5,383	1,849	1,849		5-10 years	1,849	72
73	Fully Depreciated Assets							73
74	Allocated from Home Office			4,900	4,900			74
75	TOTALS	$ 651,936	$ 32,351	$ 37,251	$ 4,900		$ 590,106	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	Van	1994	$ 27,905	$	$	$	7	$ 27,905	76
77										77
78										78
79										79
80	TOTALS			$ 27,905	$	$	$		$ 27,905	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,609,664	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 148,024	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 152,924	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 4,900	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,649,242	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Allocated from Home Office				2,836			6
7	TOTAL				$ 2,836 **			7

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: N/A *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 36,941 Description: Specialized Beds and Mattresses $29,376; Postage Machine $634; Time Clock $4,203; Copier $2,172; Management Allocation $556

C. Vehicle Rental (See instructions.) (Attach a schedule detailing the breakdown of movable equipment)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			N/A		18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES [X] NO
   It is the policy of this facility to only hire certified nurses aides.
   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10a, C2, C3	hrs	$	2,442	$ 36,723	$ 342	2,442	$ 37,065	1
2	Licensed Speech and Language Development Therapist	L10a, C3	hrs		1,737	26,054		1,737	26,054	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10a, C2, C3	hrs		3,035	45,526	27,249	3,035	72,775	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				18,366		18,366	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See attached Schedule 16A				1,108	17,079	78,311	1,108	95,390	13
14	TOTAL			$	8,322	$ 125,382	$ 124,268	8,322	$ 249,650	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Prairie Rose Health Care Center
Provider #: 0045245
01/01/03 to 12/31/03

Schedule 16A

XIV. Special Services
Line 13 Other (specify):

Service	Line Reference	Outside Practioner Units	Cost	Supplies
IV Therapy	L10a, C2, C3	1,108	16,624	2,043
Oxygen	L 39, C2			76,268
Ambulance	L 39, C3		455	
Total		1,108	17,079	78,311

See Accountants' Compilation Report

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/03 Ending: 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 105,022	$ 105,022	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance None)	579,923	579,923	3
4	Supply Inventory (priced at Cost)	10,480	10,480	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Utility deposits	2,106	2,106	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 697,531	$ 697,531	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	13,500	13,500	13
14	Buildings, at Historical Cost	2,831,711	2,893,119	14
15	Leasehold Improvements, at Historical Cost	23,204	23,204	15
16	Equipment, at Historical Cost	799,993	679,841	16
17	Accumulated Depreciation (book methods)	(1,641,348)	(1,649,242)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (sp Financing costs	400,624	400,624	22
23	Other(specify): Mortgage escrows	524,751	524,751	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,952,435	$ 2,885,797	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,649,966	$ 3,583,328	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 588,963	$ 588,963	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	35,981	35,981	29
30	Accrued Salaries Payable	59,860	59,860	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	18,253	18,253	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached Schedule 17A	186,255	186,255	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 889,312	$ 889,312	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,508,332	3,508,332	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due from Tutera	709,422	709,422	43
44	Intercompany			44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,217,754	$ 4,217,754	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,107,066	$ 5,107,066	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,457,100)	$ (1,523,738)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,649,966	$ 3,583,328	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

FACILITY NAME: Prairie Rose Health Care Center
PROVIDER # 0045245
12/31/2003

Schedule 17A

XV. BALANCE SHEET - Unrestricted Operating Fund.

C. Current Liabilities

Other Current Liabilities (specify):	Operating	After Consolidation
Medicaid Settlement	28,650	28,650
Accrued Vacation	74,587	74,587
Accrued Insurance	49,419	49,419
Other Accrued Expenses	33,599	33,599
Total Line 36 - Other Current Liabilities(specify):	**186,255**	**186,255**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,545,171)	1
2	Restatements (describe):		2
3			3
4	**Prior period adustment**	(21,222)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,566,393)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	109,293	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 109,293	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,457,100)	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,560,186	1
2	Discounts and Allowances for all Levels	(377,709)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,182,477	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	306,344	6
7	Oxygen	253,350	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 559,694	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,453	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	127,992	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	63,038	19
20	Radiology and X-Ray		20
21	Other Medical Services	291,678	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 485,161	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	10,531	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 10,531	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a	See attached Schedule 19A	672,987	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 672,987	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,910,850	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	600,781	31
32	Health Care	1,599,642	32
33	General Administration	793,633	33
	B. Capital Expense		
34	Ownership	435,625	34
	C. Ancillary Expense		
35	Special Cost Centers	311,075	35
36	Provider Participation Fee	60,801	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,801,557	40
41	**Income before Income Taxes (line 30 minus line 40)****	109,293	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 109,293	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

FACILITY NAME: Prairie Rose Health Care Center
PROVIDER # 0045245
12/31/2003

Schedule 19A

XVII. Income Statement
Line 28: Settlement Income

Description	Amount
Forgiveness of debt	671,078
Vending machine revenue	747
Miscellaneous income	1,162
Total	672,987

See Accountants' Compilation Report

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	4,073	6,233	$ 147,761	$ 23.71	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,684	6,179	120,727	19.54	3
4	Licensed Practical Nurses	23,500	23,866	395,483	16.57	4
5	Nurse Aides & Orderlies	42,401	48,342	454,856	9.41	5
6	Nurse Aide Trainees	1,300	1,335	12,728	9.53	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,257	4,667	42,937	9.20	10
11	Social Service Workers	4,019	5,690	92,061	16.18	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,738	16,507	154,588	9.36	15
16	Dishwashers					16
17	Maintenance Workers	2,288	2,723	31,560	11.59	17
18	Housekeepers	4,300	4,376	35,855	8.19	18
19	Laundry	550	600	4,082	6.80	19
20	Administrator	2,053	2,080	58,927	28.33	20
21	Assistant Administrator					21
22	Other Administrative	208	208	35,181	169.14	22
23	Office Manager	2,900	3,010	54,676	18.16	23
24	Clerical	2,745	2,753	42,067	15.28	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	700	733	6,106	8.33	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	113,716	129,302	$ 1,689,595 *	$ 13.07	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 2,837	L1, C3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	30,252	L10, C3	38
39	Pharmacist Consultant	Monthly	2,181	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	1,934	L11, C3	44
45	Social Service Consultant	Monthly	2,008	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 39,212		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ N/A		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jill West	Administrator	0%	$ 54,382
Angela Edwards	Administrator	0%	4545
Allocated From Home Office			
Mark Petersen	Administrative	*	35,181
* See Attached Schedule 6A			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 94,108

B. Administrative - Other

Description	Amount
Management Fees (eliminated in column 7)	$ 96,841
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 96,841

C. Professional Services

Vendor/Payee	Type	Amount
Threshold Data Tech	Computer Services	$ 3,144
Global Exchange Services	Computer Services	991
LTC Solutions	Computer Services	1,829
Ginoli and Company	Accounting	475
BKD	Accounting	2,301
Michael F. Flanagan, L.L.C	Legal	29,000
Brown & James	Legal	5,564
Daniel Maher Law Offices	Legal	200
Heyl Royster Voelker & Allen	Legal	2,348
Van Ostrand & Elvldge Kelley	Legal	139
Duane Morris	Legal	2,331
Bush, Snyder & Associates	Legal	2,300
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 50,622

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 77,020
Unemployment Compensation Insurance	
FICA Taxes	108,648
Employee Health Insurance	27,814
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Uniform expense	115
Other expense	6,761
Allocated from Home Office	17,299
TOTAL (agree to Schedule V, line 22, col.8)	$ 237,657

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,235
Health Care Worker Background Check	
(Indicate # of checks performed)	
Illinois Health Care Association dues	1,092
Miscellaneous dues and subscriptions	3,088
Allocated from Home Office	304
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,719

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,753
Seminar Expense	2,026
Allocated from Home Office	1,471
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,250

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Prairie Rose Health Care Center
Provider #: 0045245
01/01/03 to 12/31/03

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3)	50,622
Allocated from Management Company	
Legal	1,919
Other	12,045
Total (agree to Schedule V, line 19, column 8)	64,586

See Accountants' Compilation Report

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2	N/A												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/03 Ending: 12/31/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association: $1,092**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7.5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **14,614** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES ____ NO **x** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **60,801**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **N/A** Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **747**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **BKD** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **No** If no, please explain. **Audit currently in progress.**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT **Prairie Rose Health Care** **12:58 PM** **11/4/2005**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-250,478	equal to	-250,478	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	233,412	equal to	233,412	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	0	equal to	0	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	152,924	equal to	152,924	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	2,836	equal to	2,836	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	36,941	equal to	36,941	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	135,894	equal to	154,561	-18,667	FAILED	Pg16 Z12+Z14...	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	124,268	equal to	124,268	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	600,781	equal to	600,781	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,599,642	equal to	1,599,642	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	793,633	equal to	793,633	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	435,625	equal to	435,625	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	311,075	equal to	311,075	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	60,801	equal to	60,801	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	1,124,933	equal to	1,137,661	-12,728	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	12,728	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	42,937	equal to	42,937	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	92,061	equal to	92,061	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	154,588	equal to	154,588	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	31,560	equal to	31,560	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	35,855	equal to	35,855	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	4,082	equal to	4,082	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	94,108	equal to	94,108	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	96,743	equal to	96,743	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,689,595	equal to	1,689,595	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	2,837	< or = to	4,206	-1,369	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	0	< or = to		0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	32,433	< or = to	35,243	-2,810	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	1,934	< or = to	1,934	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	2,008	< or = to	2,008	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	94,108	equal to	94,108	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	96,841	equal to	96,841	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	50,622	equal to	50,622	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	237,657	equal to	237,657	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	5,719	equal to	5,719	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	5,250	equal to	5,250	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	60,801	equal to	60,801	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	N/A	< or = to	17,299	#VALUE!	#VALUE!	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	N/A	equal to	0	#VALUE!	#VALUE!	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	2,381	equal to	2,381	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-22,813	equal to	-22,813	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	3,544,313	equal to	3,544,313	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	N/A	equal to		0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	13,500	equal to	13,500	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	2,916,323	equal to	2,916,323	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	679,841	equal to	679,841	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	1,649,242	equal to	1,649,242	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-1,457,100	equal to	-1,457,100	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	109,293	equal to	109,293	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	3,649,966	equal to	3,649,966	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

Enter Cost Center Expenses	**YOU HAVE CHOSEN THE SUPPORT CALC. THAT IS LINK TO THE COST REPORT!!**		11/4/2005	12:58:52 PM		
HSA Number	3	Name	Prairie Rose Health Care Center			
Cost report period	From:	01/01/03	To:	12/31/03	Base Number	336
If this is an ICF/DD 16 facility, enter a 1 in cell C		N				
Licensed bed days:	44,165	Occupancy:	31,449	Pct. of occupancy:	71.21%	
Illinois Public Aid Support Rate		$				
Genl Services Salary/Wage:	226,085	Col 1, Line 8 ---Audit Adj:				
Genl Admin Salary/Wage	190,851	Col 1, Line 28 ---Audit Adj:	-35181			
Total Salary Wage	1,689,595	Col 1, Line 44 ---Audit Adj:	-35181			
Employee Benefits	237,657	Col 8, Line 22 ---Audit Adj:				
Total General Services:	603,381	Col 8, Line 8 ---Audit Adj:				
Total General Admin	747,898	Col 8, Line 28 ---Audit Adj:	-35181			

Instructions and Calculation Steps

STEP Adjust Support Service Costs to Include Correct Amounts of Fringe Benefits and Payroll Taxes

Fringe benefits and payroll taxes are reported as a lump sum under General Administration expenses on your cost report (Page 3, Column 10, Line 22). You will need to take this amount out of General Administration expenses and calculate the correct portions of this lump sum to be added to your general services and General Administration expenses. This is done by proration

A. General Services

1 Determine the proportion of general services wages to total wages.

2 Multiply the total lump sum fringe amount by this proportion to get the fringe amount for General Services.

3 Add the proportioned fringe amount to your total general services expenses to get your new total general services cost.

General Services Wages (Column 1, Line 8	$226,085
Divided by Total Wages (Column 1, Line 44	$1,654,414
General service wages as percent of total wages	13.6656%
Employee Benefits (Column 10, Line 22	$237,657
Allocation of Employee Benefits to General Services Costs	$32,477
Plus Total General Services (Column 10, Line 8	$603,381
New Total General Services Cost	$635,858

B. General Administration

1 Determine the proportion of General Administration wages to total wages.

2 Multiply the total lump sum fringe amount by the proportion to get the fringes amount for General Administration

3 Add the proportioned fringe amount to your total General Administration expenses

4 Subtract the total lump sum fringe amount from your General Administration expenses to get your new total General Administration Cost

General Administration Wages (Column 1, Line 28	$155,670
Divided by Total Wages (Column 1, Line 45	$1,654,414
General administration wages as a percent of total wages	9.4094%
Employee Benefits (Column 10, Line 22	$237,657
Allocation of Emplayee Benefits to General Admin. Cost	$22,362
Plus Total General Administration (Column 10, Line 2	$712,717
Minus Total Fringe (Column 10, Line 2:	$237,657
New Total General Administration Cos	$497,422

STEP Adjust Support Service Costs for Inflation

To calculate the impact of inflation, different inflation fators are used for the General Service and General Administration costs of your cost report. These inflation factors are listed in Table I, Inflation Multipliers. To select the appropriate inflation factors, you need to calculate your base number using the formula outlined below. Once you have calculated your base number, find it in Table I. Select the inflation factors which correspond with your base number and use these in updating your support cost.

A. Base Number Calculation

Convert the beginning and ending dates of your cost reporting period (page 1, Schedule II of your cost report) into numbers and apply the following formula:

Beginning Month + Ending Month	13	divided by 2 =	6.5
Beginning Day + Ending Day	32	divided by 60.8 =	0.526315789
Beginning Year + Ending Year =	206	multiplied by 6 =	1236
Sum of the three lines			1243.026316
Subtract from the sum			907.00
Base Number (expressed as a whole number, fraction dropped)			336

B. Select the Appropriate Inflation Multipliers

Refer to Table I, inflation Multipliers, and find the multipliers which correspond with the base number you have calculated.

General Services Multiplier	1
General Administration Multiplie	1

C. Apply Inflation Multipliers to Update Cos

1 Multiply New Total General Services Cost (from Step I-A) by the appropriate multiplier from Table

New Total General Service Cost (Step I-A)	$635,858	
General Services Multiplier (Step II-B	1	
Updated General Services Cost		$635,858

2 Multiply New Total General Administration Cos (from Step I-B)by the appropriate multiplier from Table

New Total General Service Cost (Step I-B	$497,422	
General Administration Multiplier (Step II-E	1	
Updated General Services Cost		$497,422
3 Total Updated Support Costs (1 + 2		$1,133,280

STEP I Convert Total Updated Support Costs (C-3) to Per Diem Cos

Use one of the two procedures below to compute per diem costs.

CALCULATED PER DIEM SUPPORT CO $32.70

A. If the occupancy (Cost Report, Page 2, Schedule III-C) i equal to or above 93 percent, divide your total updated support costs (Step II, C, 3, above) by the total patien days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14

Total Support Costs (Step II, C, 3, above	$1,133,280
Total Patient Days (Cost Report	31,449
Support Costs per Dien	$36.04

OR

B. If the occupancy is below 93 percent, calculate 93 percent of the licensed bed days (Cost Report, Page 2, Schedule III-A Column 4, Line 7). Then subtract the total patien days (Cost Report, Page 2, Schedule III-B, Column 5 Line 14) from the result and calculate one-third of the difference. Then add the one-third difference to the total patient days to obtain your adjusted occupancy. Next divide your total updated Support Costs (Step II, C, 3 above by your adjusted occupancy.

Licensed Bed Days	44,165
Multiplied by	0.93
	41,073
Minus total Patient Day:	31,449
	9,624
One-third of difference	3,208
Plus Total Patient Day	31,449
Adjusted Occupancy	34,657
Total Support Costs (Step II, C, 3, above	$1,133,280
Divided by Adjusted Occupany	34657
Support Costs Per Dien	$32.70

STEP IV Calculate Support Rate

The maximum allowable support reimbursement rate is the 75th percentile for your region. The 35th and 75th percentile rates by HSA are listed in Table II, support Rate Percentiles by HSA Use one of the three procedures below and refer to Table II to calculate your support rate.

A. If your support costs per diem from STEP II is equal to or greater than the 75th percentile for your HSA, then your support rate is the 75th percentile rate listed in Table I

B. If your support costs per diem from Step III is equal to or greater than the 35th percentile, but less than the 75th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate listed in Table II. Use the following procedure to calculate your rate

75 Percentile Rate for your HSA	$34.36
Minus Support Costs Per Dier	$32.70
Difference	$1.66
Multiply the Difference by	0.5
One-Half of the Difference	$0.83
Plus Support Costs Per Dier	$32.70
Support Rate if costs are between 35th and 75th percentile	33.53

C. If your support cost per diem from Step III is below the 35th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate up to a ceiling. This ceiling is equal to 50 percent of the difference between the 35th and 75th percentiles plus $.05. The ceiling for each HSA is listed in Table II. Use the following procedure to calculate your rate

75 Percentile Rate for your HSA	$34.36
Minus Support Costs Per Dier	$32.70
Difference	$1.66
Multiply the Difference by	0.5
One-Half of the Difference	$0.83
Compare one-half the difference to the profit ceiling for your HSA in Table II and	2.365
Enter the Lower of the Two Amounts	$0.830
Plus Support Costs Per Dier	$32.70
Support Rate if support costs less than 35th percentile	$33.53

D. YOUR FINAL TOTAL SUPPORT RATE from A, B, or C abc **$33.53**

75th Percentile is	$34.36
35th Percentile is	$29.73

Table
Inflation Multipliers

Base Number	General Services Multiplie	General Administration Multiplie
261	1.1187	1.1531
262	1.1182	1.1530
263	1.1178	1.1528
264	1.1071	1.1376
265	1.1067	1.1375
266	1.1062	1.1373
267	1.0975	1.1249
268	1.0971	1.1248
269	1.0966	1.1246
270	1.0887	1.1134
271	1.0882	1.1132
272	1.0877	1.1130
273	1.0815	1.1043
274	1.0811	1.1042
275	1.0806	1.1040
276	1.0730	1.0932
277	1.0725	1.0931
278	1.0720	1.0929
279	1.0666	1.0853
280	1.0661	1.0851
281	1.0657	1.0850
282	1.0588	1.0753
283	1.0583	1.0751
284	1.0579	1.0750
285	1.0535	1.0690
286	1.0531	1.0689
287	1.0527	1.0687
288	1.0413	1.0524
289	1.0409	1.0522
290	1.0404	1.0521
291	1.0321	1.0403
292	1.0317	1.0402
293	1.0313	1.0400
294	1.0254	1.0318
295	1.0250	1.0317
296	1.0246	1.0315
297	1.0228	1.0294
298	1.0224	1.0293
299	1.0219	1.0291
300	1.0166	1.0218
301	1.0162	1.0216
302	1.0158	1.0215
303	1.0076	1.0098
304	1.0072	1.0097
305	1.0067	1.0095
306	1.0000	1.0000

Table I
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	40.08	32.10	4.040
2	37.33	31.77	2.830
3	34.36	29.73	2.365
4	37.33	31.77	2.830
5	32.69	27.53	2.630
6	43.80	31.76	6.070
7	43.80	31.76	6.070
8	43.80	31.76	6.070
9	39.02	30.77	4.175
10	40.08	32.10	4.040
11	35.80	29.99	2.955

Table II (For ICF/DD 16 Facilities)
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	34.86	27.19	3.885
2	33.30	25.97	3.715
3	32.74	25.54	3.650
4	33.30	25.97	3.715
5	30.46	23.75	3.405
6	40.44	31.54	4.500
7	40.44	31.54	4.500
8	40.44	31.54	4.500
9	37.60	29.32	4.190
10	34.86	27.19	3.885
11	32.73	25.52	3.655

Capital Rate Data
Change print Orientation!

YOU HAVE CHOSEN THE CAPITAL CALC. THAT IS LINKED TO THE COST REPORT!!!! 11/4/2005 12:58:52 PM
COSTS INCLUDED ON PAGES 12 THRU 12D START AT CELL O6

Facility Name: **Prairie Rose Health Care Center** ID: **0045245**

HSA No.: ? Own or Rent? (O or R) ____ Own or Rent Beginning: ____

IF RENTED, have facilities been continously rented from an unrelated party since prior to January 1, 1978 (Y or N): or since the first day of operation for buildings constructed since January 1, 1978? N

Cost Report Pd:		Licensed Beds:	121	Total Patient Days	31,449
Begin	**01/01/03**	Licensed Bed Days:	44,165	% Occupied	71.21%
End	**12/31/03**			Capital Days	41,073

1989 Property Tax COST: ____ (Actual dollar amount 1989 taxes)

1991 Property Tax RATE: ____ (Inflated dollar amount divided by 1991 capital days)

FY 1991 Capital Rate: ____ (From form 787)

CAPITAL CALCULATIONS

	Calculation Column
A. Determine the base year for your building from Work Table A	1985
B. Determine the Building Specific historical cost per bed:	
1. Work Table A, Line 24, Column (B)	2916323
2. Total licensed beds from cost report Page 2, Line 7, column 3	121
3. Line 1 divided by Line 2	$24,102
4. Regional construction inflator from Table 2	#N/A
5. Building specific historical Cost ber bed (Line 3 * Line 4, round to even $)	#N/A
C. Obtain the Uniform Building Value from Table 1	#VALUE!
D. The capital rate will be calculated through a blending of the uniform building value from Line C and the building specific historical cost per bed from Line B5	
1. Building specific historical cost from Line B5	#N/A
2. Uniform building value from Line C	#VALUE!
3. Add Lines 1 and 2	#VALUE!
4. Divide by 2 to obtain average	#VALUE!
5. Enter 120% of line C	#VALUE!
6. The blended value is the lesser of Line 4 or Line 5	#VALUE!
E. Divide the blended value from step D by 339 days to obtain a per diem blended value investment	#VALUE!
F. Multiply the per diem blended value from step E by the applicable rate of return to obtain the building rate factor. (The rate of return is 11% for 1979 and later base years and 9.13% for 1978 and older base years.)	#VALUE!
G. Add $2.50 to Line F for equipment, rent, vehicle and working capital.	2.5
H. Add Lines F & G to obtain the preliminary capital rate	#VALUE!
I. Implementation Capital Rate. (This step does not apply if the facility has been constructed or purchased after FY91.)	
1. Enter the FY 91 capital rate	0
2. Subtract the FY 91 property tax rate	0
3. FY 91 rate without tax	0
4. Multiply Line I3 by 115%	x 1.15%
5. Implementation capital rate	0

J. Property Tax
Property taxes are taken from the Long Term Care Property Tax Statement which was submitted to the Department of Public Aid during FY93. Reimbursement for real estate taxes is based upon the actual 1991 taxes for which the nursing homes were assessed. The formula used is a follows:

1. Property Tax Expense (Long Term Care Property Tax Statement, Column D, Total.)	0
2. Divided by: Capital Days (see below)	41,073
3. Equals: Per Diem Cost	$0.00
4. Times: Property Tax Inflator (Table 3)	#N/A
5. Equals: Updated Property Tax Cost	#N/A

Capital Days
The capital days are the higher of the actual census (Page 2, Schedule III-B, Column 5, Line 14) or 93% of licensed bed days (page 2, Schedule III-A, Column 4, Line 7 * .93.)

1. Total Patient Days	31,449
2. Total Licensed Bed Days * .93	41073
3. Capital Days (higher of Line 1 or Line 2)	41,073

K. Total Capital Rate for FY 94

1. Enter the greater of the simplified system rate from Line H or the implementation capital rate from Line I	#VALUE!
2. Add Property Tax from Line J5	#N/A
3. Total capital rate (add Lines 1 & 2)	#VALUE!

WORK TABLE A

		Year Acquired (A) Last 2 digits only	Cost (B)	Columns (A) * (B) (C)	Linked Page
1	1	76	1068665	81218540	12
2	2	0	0	0	12
3	3	0	0	0	12
4	4	0	0	0	12
5	5	0	0	0	12
6	6	86	970363	83451218	12
7	7	87	110922	9650214	12
8	8	89	2219	197491	12
9	9	90	4295	386550	12
10	10	91	134283	12219753	12
11	11	92	17130	1575960	12
12	12	93	24239	2254227	12
13	13	94	10559	992546	12
14	14	95	14617	1388615	12
15	15	96	305057	29285472	12
16	16	97	23542	2283574	12
17	17	98	9120	893760	12
18	18	98	3850	377300	12
19	19	98	4884	478632	12
20	20	98	2358	231084	12
21	21	98	6102	597996	12
22	22	99	1484	146916	12
23	23	99	2397	237303	12
24	24	99	2008	198792	12
25	25	100	1876	187600	12
26	26	101	1215	122715	12
27	27	101	94315	9525815	12
28	28	101	1900	191900	12
29	29	101	1174	118574	12
30	30	101	22030	2225030	12
31	31	0	0	0	12
32	32	0	0	0	12
33	33	0	0	0	12
34	34	102	2490	253980	12A
35	35	102	5617	572934	12A
36	36	102	7909	806718	12A
37	37	102	11300	1152600	12A
38	38	102	3106	316812	12A
39	39	102	7650	780300	12A
40	40	102	805	82110	12A
41	41	102	36842	3757884	12A
42	42	0	0	0	12A
43	43	0	0	0	12A
44	44	0	0	0	12A
45	45	0	0	0	12A
46	46	0	0	0	12A
47	47	0	0	0	12A
48	48	0	0	0	12A
49	49	0	0	0	12A
50	50	0	0	0	12A
51	51	0	0	0	12A
52	52	0	0	0	12A
53	53	0	0	0	12A
54	54	0	0	0	12A
55	55	0	0	0	12A
56	56	0	0	0	12A
57	57	0	0	0	12A
58	58	0	0	0	12A
59	59	0	0	0	12A
60	60	0	0	0	12A
61	61	0	0	0	12A
62	62	0	0	0	12A
63	63	0	0	0	12A
64	64	0	0	0	12A
65	65	0	0	0	12A
66	66	0	0	0	12A
67	67	0	0	0	12B
68	68	0	0	0	12B
69	69	0	0	0	12B
70	70	0	0	0	12B
71	71	0	0	0	12B
72	72	0	0	0	12B
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74	74	0	0	0	12B
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78	78	0	0	0	12B
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86	86	0	0	0	12B
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88	88	0	0	0	12B
89	89	0	0	0	12B
90	90	0	0	0	12B
91	91	0	0	0	12B
92	92	0	0	0	12B
93	93	0	0	0	12B
94	94	0	0	0	12B
95	95	0	0	0	12B
96	96	0	0	0	12B

	Year Acquired (A) Last 2 digits only	Cost (B)	Columns (A) * (B) (C)	Linked Page
97	0	0	0	12B
98	0	0	0	12B
99	0	0	0	12C
100	0	0	0	12C
101	0	0	0	12C
102	0	0	0	12C
103	0	0	0	12C
104	0	0	0	12C
105	0	0	0	12C
106	0	0	0	12C
107	0	0	0	12C
108	0	0	0	12C
109	0	0	0	12C
110	0	0	0	12C
111	0	0	0	12C
112	0	0	0	12C
113	0	0	0	12C
114	0	0	0	12C
115	0	0	0	12C
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129	0	0	0	12C
130	0	0	0	12C
131	0	0	0	12D
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157	0	0	0	12D
158	0	0	0	12D
159	0	0	0	12D
160	0	0	0	12D
161	0	0	0	12D
162	0	0	0	12D

Base year:
Total of Column C/Total of Column B = Base Year

248160915 2916323 85.09376876

Base Year = 1985

TABLE 1 error

Table 1 Uniform building Value

Uniform Building Value

Base year	6, 7, 8 & 9	1, 2, 3, 4, 5, 10 & 11
1970	4114	3766
1971	5348	4896
1972	6583	6026
1973	7817	7155
1974	9051	8285
1975	10285	9415
1976	11519	10545
1977	12754	11675
1978	13988	12804
1979	15222	13934
1980	16456	15064
1981	17691	16194
1982	18925	17324
1983	20159	18453
1984	21393	19583
1985	22628	20713
1986	23862	21843
1987	25096	22973
1988	26330	24102
1989	27564	25232
1990	28799	26362
1991	30033	27492
1992	31267	28622
1993	32501	29751
1994	33736	30881
1995	34970	32011
1996	36204	33141
1997	37438	34271
1998	38673	35400
1999	39907	36530
2000	41141	37660

Use the 1970 values for all years prior to 1970

TABLE 2 #N/A

Construction Inflators by year and HSA
(Note: Use the 1960 Inflators for all years prior to 1960)
(For the FY94 Nursing Facility Rate Calculation Packet)

Year	1, 2 & 10	3, 4 & 5	11	6, 7, 8 & 9
1960	6.26	6.08	6.29	6.54
1961	5.67	5.52	5.66	5.87
1962	5.67	5.52	5.66	5.87
1963	5.67	5.52	5.66	5.87
1964	5.67	5.52	5.66	5.87
1965	5.67	5.52	5.66	5.87
1966	5.36	5.23	5.35	5.55
1967	5.1	4.97	5.08	5.28
1968	4.85	4.71	4.83	5.03
1969	4.61	4.48	4.59	4.79
1970	4.38	4.25	4.36	4.56
1971	4.01	3.89	3.98	4.15
1972	3.64	3.53	3.63	3.78
1973	3.36	3.26	3.36	3.48
1974	3.08	3	3.09	3.19
1975	2.83	2.77	2.8	2.91
1976	2.73	2.65	2.74	2.82
1977	2.57	2.48	2.55	2.68
1978	2.37	2.29	2.38	2.49
1979	2.18	2.12	2.21	2.32
1980	1.96	1.92	2.02	2.08
1981	1.8	1.76	1.86	1.91
1982	1.67	1.63	1.72	1.76
1983	1.54	1.5	1.57	1.65
1984	1.51	1.47	1.55	1.62
1985	1.48	1.45	1.5	1.59
1986	1.46	1.42	1.46	1.55
1987	1.44	1.4	1.43	1.52
1988	1.4	1.36	1.39	1.46
1989	1.35	1.33	1.35	1.41
1990	1.32	1.31	1.33	1.34
1991	1.29	1.29	1.3	1.31
1992	1.26	1.26	1.27	1.26
1993	1.25	1.24	1.25	1.23
1994	1.22	1.22	1.22	1.19
1995	1.2	1.2	1.19	1.17
1996	1.12	1.11	1.13	1.12
1997	1.1	1.09	1.1	1.1
1998	1.08	1.07	1.07	1.07
1999	1.04	1.04	1.04	1.04
2000	1.02	1.02	1.02	1.03
2001	1.00	1.00	1.00	1.00
2002	1.00	1.00	1.00	1.00

TABLE 3

Property Tax Inflator

HSA	Rate
1	1.05723
2	1.0395
3	1.0333
4	1.03302
5	1.03753
6	1.02368
7	1.02054
8	1.02613
9	1.01315
10	1.0815
11	1.03527

TABLE 4

Table 2 column

HSA	Column
1	1
2	1
3	2
4	2
5	2
6	4
7	4
8	4
9	4
10	1
11	3

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	154,588	10,738	4,206	169,532	0	169,532	220	169,752
2. Food Purchase	0	119,602	0	119,602	0	119,602	-747	118,855
3. Housekeeping	35,855	9,882	51,081	96,818	0	96,818	0	96,818
4. Laundry	4,082	11,925	32,534	48,541	0	48,541	0	48,541
5. Heat and Other Utilities	0	0	84,998	84,998	0	84,998	595	85,593
6. Maintenance	31,560	2,672	47,058	81,290	0	81,290	2,532	83,822
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	226,085	154,819	219,877	600,781	0	600,781	2,600	603,381
9. Medical Director	0	0	0	0	0	0	0	0
10. Nursing & Medical Records	1,137,661	132,619	35,243	1,305,523	0	1,305,523	0	1,305,523
10a. Therapy	0	29,634	124,927	154,561	0	154,561	0	154,561
11. Activities	42,937	505	1,934	45,376	0	45,376	0	45,376
12. Social Services	92,061	113	2,008	94,182	0	94,182	0	94,182
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	1,272,659	162,871	164,112	1,599,642	0	1,599,642	0	1,599,642
17. Administrative	94,108	0	96,841	190,949	0	190,949	-96,841	94,108
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	50,622	50,622	0	50,622	13,964	64,586
20. Fees, Subscriptions & Promotion	0	0	5,415	5,415	0	5,415	304	5,719
21. Clerical & General Office	96,743	11,474	48,795	157,012	0	157,012	15,309	172,321
22. Employee Benefits & Payroll	0	0	220,358	220,358	0	220,358	17,299	237,657
23. Inservice Training & Education	0	0	0	0	0	0	432	432
24. Travel and Seminar	0	0	3,779	3,779	0	3,779	1,471	5,250
25. Other Admin. Staff Trans	0	0	4,585	4,585	0	4,585	1,565	6,150
26. Insurance-Prop.Liab.Malpractice	0	0	160,913	160,913	0	160,913	762	161,675
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	190,851	11,474	591,308	793,633	0	793,633	-45,735	747,898
29. Total General Administrative	1,689,595	329,164	975,297	2,994,056	0	2,994,056	-43,135	2,950,921
30. Depreciation	0	0	147,263	147,263	0	147,263	5,661	152,924
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	233,822	233,822	0	233,822	-410	233,412
33. Real Estate	0	0	0	0	0	0	0	0
34. Rent - Facility & Grounds	0	0	0	0	0	0	2,836	2,836
35. Rent - Equipment & Vehicles	0	0	36,385	36,385	0	36,385	556	36,941
36. Other (specify):*	0	0	18,155	18,155	0	18,155	0	18,155
37. Total Ownership	0	0	435,625	435,625	0	435,625	8,643	444,268
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	94,634	455	95,089	0	95,089	0	95,089
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	60,801	60,801	0	60,801	0	60,801
43. Other (specify):*	0	0	215,986	215,986	0	215,986	-215,986	0
44. Total Special Cost Ce	0	94,634	277,242	371,876	0	371,876	-215,986	155,890
45. Grand Total	1,689,595	423,798	1,688,164	3,801,557	0	3,801,557	-250,478	3,551,079

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	105,022	105,022
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	579,923	579,923
4. Supply Inventory	10,480	10,480
5. Short-Term Investments	0	0
6. Prepaid Insurance	0	0
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	2,106	2,106
10. Total current assets	697,531	697,531
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	13,500	13,500
14. Buildings, at Historical Cost	2,831,711	2,893,119
15. Leasehold Improvements, Historical Cost	23,204	23,204
16. Equipment, at Historical Cost	799,993	679,841
17. Accumulated Depreciation (book methods)	-1,641,348	-1,649,242
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	400,624	400,624
23. other (specify):	524,751	524,751
24. Total Long-Term Assets	2,952,435	2,885,797
25. Total Assets	3,649,966	3,583,328
CURRENT LIABILITIES		
26. Accounts Payable	588,963	588,963
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	35,981	35,981
30. Accrued Salaries Payable	59,860	59,860
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	18,253	18,253
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	186,255	186,255
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	889,312	889,312
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	3,508,332	3,508,332
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	709,422	709,422
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	4,217,754	4,217,754
46.Total Liabilities	5,107,066	5,107,066
47.Total Equity	-1,457,100	-1,523,738
48.Total Liabilities and Equity	3,649,966	3,583,328

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,560,186
2. Discounts and Allowances for all Levels	-377,709
Subtotal - Inpatient Care	2,182,477
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	306,344
7. Oxygen	253,350
Subtotal - Anciliary Revenue	559,694
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	2,453
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	127,992
18. Sale of Supplies to Non-Patients	0
19. Laboratory	63,038
20. Radiologyand X-Ray	0
21. Other Medical Services	291,678
22. Laundry	0
Subtotal - Other Operating Revenue	485,161
24. Contributions	0
25. Interest and Other Investments Income	10,531
Subtotal - Non-Operating Revenue	10,531
27. Other Revenue (specify):	0
28. Other Revenue (specify):	672,987
Subtotal - Other Revenue	672,987
30. Total Revenue	3,910,850
31. General Services	600,781
32. Health Care	1,599,642
33. General Administration	793,633
34. Ownership	435,625
35. Special Cost Centers	311,075
35. Provider Participation Fee	60,801
37. Other	0
40. Total Expenses	3,801,557
41. Income Before Income Taxes	109,293
42. Income Taxes	0
43. Net Income or Loss for the Year	109,293

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23	Provider Participation fee is linked from page 4